COMPONENT II: Funding Opportunity G:

Primary Health Care

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I. PROGRAM INFORMATION

A. Introduction

The Texas Department of Health (TDH) Primary Health Care (PHC) Program announces the expected availability of fiscal year (FY) 2004 general revenue to provide opportunities to communities to identify, design, and implement comprehensive, preventive, and primary care services for medically indigent persons.

B. Eligible Applicants

General revenue funds will be awarded to agencies currently funded in Texas under the Primary Health Care program to continue projects providing or accessing care for medically indigent persons.

Approximately $14,000,000 is expected to be available to fund about 50 projects. The specific dollar amount awarded to each applicant depends upon the merit and scope of the proposed project.

It is expected that the contract will begin on or about September 1, 2003, and will be made for a 12-month budget period.

C. Use of Funds

Funds are awarded for a specifically defined purpose and shall not be used for any other project. Funds may be used to support services that are provided. Funds shall not be used to supplant local or state funds.

Priority Services:

- Preventive health services including immunizations, health screening, and well child
- Diagnosis and treatment
- Family planning
- Health education
- Diagnostic tests: laboratory, x-ray, and nuclear medicine, and
- Emergency services.

Optional Services that may be funded after the above services are provided or ensured include:

- Prescription drugs, medical devices, and durable supplies
- Transportation
- Dental care
- Podiatry services
- Nutritional services
- Home health care
- Environmental health services, and
- Social services

In addition to the provisions described in COMPONENT I - Information, Content and Required Forms, Primary Health Care funds must be used for providing or accessing care for medically indigent persons.

Other funding sources must be used first, such as Medicaid, Medicare, County Indigent Health Care, Texas Health Steps, Title V Maternal and Child Health Program, Children's

Health Insurance Program (CHIP), etc. All other funding sources must be explored before PHC funds are used.

Inpatient services are not covered.

D. Program Review Process/Evaluation Criteria

Renewal applications are initially screened for completeness. Applications meeting the preliminary screening requirements will be reviewed by teams in the central office of TDH and the public health region(s) which include(s) the geographic region of the proposed project, using a standardized review process and evaluation criteria. Recommendations will be discussed and staff will jointly make the final determination of funding. All applications will remain with TDH and will not be returned to the applicant.

FORM G1: RENEWAL APPLICATION CHECKLIST

Legal Name of _____

INSTRUCTIONS: This Checklist may be completed and submitted with the original renewal application. It is provided to ensure that the application is complete, proper signatures are included, and the required assurances, certifications and attachments have been submitted. Application is typed (computer or typewriter), single-spaced on 8 ½ " x 11" white paper and does not exceed page limits where specified.

FORM	REQUIRED COMPONENT I FORMS	Included	Not Applicable
1	Face Page completed, and proper signatures and date included		
2	Contact Person (Administrative and Program) Information included		
3	Administrative Information (with supplemental documentation attached if required) included		
4	Medicaid Provider Status Table completed and included if Titles V (Fee), X, or XX applicant		
5	Nonprofit Board of Directors and Executive Director Assurances form signed and included		
6	Copy(ies) mailed to appropriate Regional Director for proposed area(s) to be served		

FORM	FUNDING OPPORTUNITY G – Primary Health Care	Included	Not Applicable
G2	Performance Measures included		
G3	Service Delivery Plan included		
G4	Primary Health Care Program Assurances signed and included		
G5-G5-8	Service Information/Population/Costs and Budget forms completed and included		

FORM G2: PERFORMANCE MEASURE GUIDELINES

Applicant shall include the performance measures in the renewal application along with the proposed target levels of performance for each measure. The proposed target levels of performance and reporting frequency will be negotiated and agreed upon by applicant and TDH, if the applicant is selected to negotiate a contract.

Impact objective: This is an objective that addresses the desired short-term, behavioral results. The target is usually reached in two-three years (should be the same as FY 2002 – year one). It describes changes in knowledge or attitudes, a demonstration of new skills or of changes in behavior or environmental influences. One way to write impact objectives is to consider the determinants and contributing factors behind a health concern. These will be in the objective:

- What risk factor is to be changed?
- To whom is the change directed?
- Where will this change occur?

Next, identify and list the following quantitative elements that will be in the objective:

- How much will the health indicator/problem be changed?
- By when will these changes occur?

Process Objective: This is an objective that addresses the implementation of program or service activities. It describes the levels of health services, health education and/or other interventions that will help to achieve the impact and/or the outcome objective. Essentially, the process objective counts the services provided. These objectives are short-term, usually one year. The target dates for these objectives occur before the target dates for the corresponding impact objective (set at 2-3 years).

To write a process objective, use the impact objective. First, identify and list the following qualitative elements that will be in the objective:

- What kind of intervention is appropriate to produce the needed impact?
- To whom will the processes be directed?
- Where will the intervention/activity occur?

Next, identify and list the following quantitative elements that will be in the objective:

- How much use of the intervention will occur?
- By what date or during what time period will the intervention/activities occur?

A process objective must also be submitted to address the target number of clients to be served during the upcoming fiscal year.

Activities: Activities are a series of work statements that describe how the process objectives will be accomplished.
For example:

Goal: (as identified in FY 2002): Reduce the incidence of obesity in ABC county adults.

Outcome objective (usually won't change because it is targets 15-10 years): By 2008, reduce the proportion of obese ABC county adults from 30% in 2001 to the current state average of 25% (Percentages from the FY 2000 Behavioral Risk Factor Survey).

Impact Objective: (Revisions to FY 2002 application in bold): By September 2005, increase to **20%** the percentage of ABC county adults participating in physical activity 2-3 times a week (baseline: 10%.

FORM G2: PERFORMANCE MEASURE GUIDELINES, continued

Process objectives (FY 2003): list these and indicate progress towards each
By September 2005, increase to 50% the percentage of county health department adult clients attending the Work Wellness into Your Life class (Baseline: 30%) - on target for meeting objective.

Process Objective (FY 2004): list new/revised process objective for the coming fiscal year.
By September 2005, increase to 65% the percentage of county health department adult clients attending the Work Wellness in to Your Life class (Baseline: 50%).

Activities: Health educators will provide the Work Wellness into Your Life classes at least quarterly.

FORM G2: PERFORMANCE MEASURES

Applicant agrees that performance measures(s) will be used to assess, in part, the applicant's effectiveness in providing the services described. Address all of the requirements (see PERFORMANCE MEASURES Guidelines) associated with the services proposed in this renewal application. ***A maximum of two (2) additional pages may be attached if needed.***

SPECIAL INSTRUCTIONS:

Submit the goals and objectives from FY 2002 RFP application; indicating progress towards meeting process and impact objectives.

Additionally, applicant should submit new process objectives and a list of activities for each impact objective written in FY 2002. If there are revisions in the proposed target level of performance for either the impact or outcomes objectives, please highlight (bold).

A process measure should also be submitted to address the projected number of clients the agency will serve with Primary Health Care funds.

Please refer to instructions for examples.

FORM G3: SERVICE DELIVERY PLAN Guidelines

Applicant shall describe the plan for service delivery to the population in the proposed service area(s) and include time lines for accomplishments. Answer question 1 whether or not changes have been made. Complete questions 2-6 only if changes have been made to last year's (FY 2003) RFP; otherwise state NO CHANGE.

1. Summarize the proposed services, population to be served, location (counties to be served), etc. Also state whether you will serve individuals from counties outside your stated service area.

2. Describe **any changes** from the FY 2003 delivery systems, workforce (attach organizational chart), policies, support systems (i.e., training, research, technical assistance, information, financial and administrative systems) and other infrastructure available to achieve service delivery and policy-making activities. If no change from previous year, state NO CHANGE.

3. Describe **any changes** to how data is collected and tabulated, who will be responsible for data collection and reporting, and how often data collection activities will occur. If no change from previous year, state NO CHANGE.

4. Describe **any changes** in coordination with the other health and human services providers in the service area(s) and delineate how duplication of services is to be avoided. If no change from previous year, state NO CHANGE.

5. Describe **any changes** in ability to provide services to culturally diverse populations (e.g., use of interpreter services, language translation, compliance with ADA requirements, and other means to ensure accessibility for the defined population). If no change from previous year state NO CHANGE.

6. Describe **any changes** to your internal Quality Assurance/Quality Improvement (QA/QI) process used to monitor services, identify staff that utilize them and identify who is responsible for ensuring they are updated. If no change from previous year, state NO CHANGE.

FORM G3: SERVICE DELIVERY PLAN

Applicants should describe plan for service delivery to the population in the proposed service area(s). The plan should address item 1 and any changes to items 2-6 listed below. ***A maximum of 2 pages***

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1. Proposed services, population to be served, location (counties to be served):

2. Delivery systems, workforce, policies, support systems and other infrastructure available to achieve service delivery and policy-making activities:

3. Data collection:

4. Coordination with the other health and human services providers in the service area(s):

5. Provision of services to culturally diverse populations:

6. Quality Assurance/Quality Improvement (QA/QI) process:

FORM G4: PRIMARY HEALTH CARE PROGRAM ASSURANCES

If my agency or I is(am) awarded a Primary Health Care (PHC) contact through this renewal application process, I agree to provide PHC services in compliance with the requirements of the Texas Department of Health and the Primary Health Care Program.

(a) To provide all PHC health services according to the most current standards and guidelines mandated by PHC.

(b) To provide all PHC health services in a culturally sensitive and nondiscriminatory manner.

(c) To provide all PHC health services as outlined in this renewal application and to notify Primary Health Care Program prior to any significant departures from this plan.

(d) To ensure that there is a structure and process for ongoing community participation in health planning, education, outreach, and evaluation. To ensure that the program observes a policy of inclusiveness for all sectors of the community.

(e) To ensure that program vision and activities are directed at the health of the entire community and not limited to clients presenting for services.

(f) To screen all clients using an approved screening tool for potential program eligibility.

(g) To bill Medicaid for the provision of all programs including Medicaid allowable services provided to appropriately eligible client. To bill PHC for approved services provided only to PHC eligible clients.

(h) To bill PHC for approved services provided only to PHC-eligible clients.

(i) To provide all PHC-approved health services to clients at or below 150% of the federal poverty income level (FPIL).

(j) To charge PHC-eligible clients only a co-pay amount based on a PHC-program guideline.

(k) To provide PHC services to PHC-eligible clients regardless of their ability to pay.

(l) To comply with all contractually specified monitoring, evaluation, and reporting requirements by specified time lines.

(m) To share pertinent data/information, within the constraints of confidentiality, with other area providers in order to eliminate overlap or duplication of services and provide clients with the best possible and most effective care.

(n) To collaborate with the applicable TDH Public Health Regional Office to develop coordinated systems of care and to enhance access to services by participating in the development of regional and community health/social service coalitions.

(o) To provide assistance to TDH Public Health Regional Office and other public health entities during public health emergencies.

The above certifications and assurances are made as a required element of the proposal to which they are attached, understanding that the truthfulness of the facts affirmed here and the continuing compliance with these requirements are conditions precedent to the award or renewal of the related contract.

_____ _____

Authorized Signature Date

FORM G5: BUDGET SUMMARY

Legal Name of Applicant: _____

Cost Categories	TDH Funds Requested (1)	Direct Federal Funds (2)	Other State Agency Funds* (3)	Local Funding Sources (4)	Other Funds (5)	Total (6)
A. Personnel	$	$	$	$	$	$
B. Fringe Benefits	$	$	$	$	$	$
C. Travel	$	$	$	$	$	$
D. Equipment	$	$	$	$	$	$
E. Supplies	$	$	$	$	$	$
F. Contractual	$	$	$	$	$	$
G. Construction	N/A 0	N/A 0	N/A 0	N/A 0	N/A 0	N/A
H. Other	$	$	$	$	$	$
I. Total Direct Costs	$	$	$	$	$	$
J. Indirect Costs	$	$	$	$	$	$
K. Total (Sum of I and J)	$	$	$	$	$	$
L. Program Income - Projected Earnings	$	$	$	$	$	$

Indirect costs are based on (mark the statement that is accurate):

☐ The applicant's most recently approved indirect cost rate _____ % A copy is attached behind the OTHER Budget Category Detail Form (FORM G5-6).

☐ The applicant's most recently approved indirect cost rate _____ % which is on file with TDH's Contract Policy and Monitoring Division.

☐ Uniform Grant Management Standards. Complete an INDIRECT COST Budget Category Detail Form (FORM G5-7).

***Letter(s) of good standing that validate the applicant's programmatic, administrative, and financial capability must be placed after this form if applicant receives any funding from other non-TDH state agencies. If the applicant is a state agency or institution of higher education, letter(s) of good standing are not required. DO NOT include non-project related funding in column 3.**

FORM G5-1: PERSONNEL Budget Category Detail Form

Legal Name of Applicant: _____

Functional Title + Code E=Existing or P=Proposed	% Time	Certification/ License Required	Total Annual Salary	Salary Requested for Project	Vacant Y/N	Justification

FRINGE BENEFITS: Itemize the elements of fringe benefits in this space. Attach an additional sheet of paper if more space is required.

Salary Total	$
Fringe Benefit Rate %	%
FRINGE BENEFITS TOTAL	$

FORM G5-2: TRAVEL Budget Category Detail Form

Legal Name of Applicant: _____

Local Travel Costs (mileage plus per diem)

Mileage Reimbursement Rate	Estimated Number of Miles	Estimated Mileage Cost (a)	Estimated Per Diem Costs (b)	Estimated Total Local Travel Costs (a) + (b)	Justification (include who or what position will be traveling, area or locations to cover, and why local travel is necessary to accomplish the project)
$		$	$	$	

Conference/Workshop Costs

Name and/or Description of Conference/Workshop	Location (City)	No. of Applicant Employees Attending (for whom TDH funds are requested)	Estimated Travel Cost (# of miles x reimbursement rate; estimated airfare, etc.)		Estimated Per Diem Cost	Estimated Related Travel Costs (taxi, etc.)	Estimated Total Conference/ Workshop Cost	Justification
TOTAL for Conf/Workshop TRAVEL:				$	$	$	$	

Local TRAVEL Costs: $	**Conf/Workshop TRAVEL Costs:** $	**Total TRAVEL Costs:** $

NOTE: All contracts with the Texas Department of Health require that a written travel policy be maintained by the contracting entity. Attach a copy of the travel policy as an appendix to the proposal. If a written travel policy is not in place, TDH's travel policy will be used.

FORM G5-3: EQUIPMENT Budget Category Detail Form

Legal Name of Applicant: _____

Itemize, describe and justify the list below. Attach complete specifications or a copy of the purchase order. See attached sample for equipment definition and detailed instructions to complete this form.

DESCRIPTION OF ITEM (e.g. $1,000 or Exception)	COST PER UNIT / # OF UNITS	UNIT TOTAL	PURPOSE & JUSTIFICATION
TOTAL Amount Requested for EQUIPMENT:		$	

FORM G5-4: SUPPLIES Budget Category Detail Form

Legal Name of Applicant: _____

Itemize, describe and justify the supply items listed below. Costs may be categorized by each general type (e.g., office, computer, medical, educational, janitorial, etc.). See attached sample for definition of supplies and detailed instructions to complete this form.

DESCRIPTION OF ITEM (e.g., $1,000 excluding equipment exceptions)	COST PER UNIT / # OF UNITS	UNIT TOTAL	PURPOSE & JUSTIFICATION
TOTAL Amount Requested for SUPPLIES:		$	

FORM G5-5: CONTRACTUAL Budget Category Detail Form

Legal Name of Applicant: _____

List contracts for services related to the scope of work that are to be provided by a third party. If a third party is not yet identified, describe the service to be contracted and show contractors as "To Be Named." Justification for any contract that delegates a substantial portion of the scope of the project, i.e., $25,000 or 25% of the applicant's funding request, whichever is greater, must be attached behind this form.

CONTRACTOR NAME (Agency or Individual)	DESCRIPTION OF SERVICES (Scope of Work)	METHOD OF REIMBURSEMENT (Unit Cost or Cost Reimbursement)	# of Hours or Units of Service	UNIT COST RATE (If Applicable)	CONTRACTOR TOTAL	JUSTIFICATION

TOTAL Amount Requested for CONTRACTUAL: $

FORM G5-6: OTHER Budget Category Detail Form

Legal Name of Applicant: _____

DESCRIPTION	(# of units x unit cost if applicable)	COST	PURPOSE & JUSTIFICATION

TOTAL Amount Requested for OTHER:	$

FORM G5-7: INDIRECT COST Budget Category Detail Form

Legal Name of Applicant: _____

Complete this form if requesting funds for indirect costs based on Uniform Grants Management Standards. The justification should include an explanation of the purpose of the service and how it is necessary for the completion of the activity.

DESCRIPTION	PURPOSE & JUSTIFICATION
Total Amount Requested for INDIRECT COST:	$

FORM G5-8: SERVICE INFORMATION/POPULATION & COSTS

Provide the information pertaining to the estimated population to be served and related costs for the PHC program. This page provides summary services and budget information. Include the number of clients that PHC funds would serve and costs to be charged to PHC or to be funded by PHC. The service population **is only the number of PHC eligible clients projected to be served, not the number of people screened or total number of people served in your clinic.** Do not duplicate or include numbers from another program. **Be sure these numbers are consistent with numbers throughout the proposal.**

SERVICE POPULATION

Total number of unduplicated PHC-eligible clients to be served with PHC funds during budget period. This number should reflect the number of unduplicated eligible persons actually receiving services; it should not be the total number of people screened for potential eligibility for all programs.

FY 04 PROJECTED NUMBER SERVED

Full-Service PHC Clients: (a) _____

Supplemental-Service PHC Clients: (b) _____

Presumptive Eligible Only (never to be enrolled in any category above) Clients: (c) _____

TOTAL PHC-ELIGIBLE CLIENTS (total a through c) _____

What percentage is this of the target population? _____ %

FY 04 PROPOSED COSTS
(Of PHC Grant $ Only)

Administrative Costs: (If over 10%, attach explanation behind this page.) (d) $ _____ _____ %

Direct Services Costs: (e) $ _____ _____ %

Total of State Funds Requested: (d+e) $ _____ _____ %

Estimated Program Income to be collected: $_____

Average Cost Per Client $_____

(Total state funds requested plus program income to be collected/ # PHC clients to be served)